PLEASE BEAR DOWN

RHODE ISLAND PRE-HOSPITAL EXPOSURE FORM

INSTRUCTIONS: Exposed pre-hospital worker completes *Part A* and presents it at hospital emergency department. Hospital ED completes *Part B,* then detaches the carbon copy and presents it to the exposed worker to return to his/her Designated Officer. Appropriate hospital department then completes *Part C* and contacts the exposed worker's Designated Officer (named in *Part A*), regardless of findings.

PART A

Report Date	Time	Incident Date	Time	Receiving Facility for Source Patient

Exposed Worker's Service/Department	Runsheet Lithocode Number

Exposed Worker Information ***(please print)***

Name _____ **Home Phone** _____ *(optional)*

Designated Officer _____ **Phone** _____

Check boxes which best indicate your exposure. Explain fully in the description space below.

Exposure Route	Bodily fluid splash to
☐ Needlestick from used needle ☐ Injury causing break to skin ☐ Bite (causing skin break) ☐ Unprotected mouth-to-mouth CPR ☐ Other _____ ☐ Inhalation _____	☐ Eye ☐ Mouth ☐ Nose ☐ Non-Intact skin ☐ Other _____
Exposure Type	**Source Patient**
☐ Blood ☐ Sputum ☐ Saliva ☐ Other (*describe*) _____	Name _____ Transp. To _____ D.O.B. _____ Transp. From _____ Location *(when exposure form filed)* _____

Exposed body part(s) ***(be specific)*** _____

_____

Describe the nature of the exposure _____

_____

Have you had Hepatitis B vaccine? ☐ yes ☐ no **Hepatitis B antibody status?** ☐ positive ☐ negative ☐ unknown

Protective gear used? ☐ gown ☐ mask ☐ eye shield/goggles ☐ gloves ☐ none ☐ other *(describe)*_____

Did you seek medical attention? ☐ yes ☐ no

Where? _____

Signature of Exposed Worker _____

PART B

Exposed worker presented to facility _____ *(name of facility)*

Initial Hospital Disposition (*check all that might apply)*

☐ Seen by physician in ED ☐ Referred to private or contract physician Medical F/U Indicated ? ☐ yes ☐ no

☐ Refused to be seen by ED physician ☐ Plans to see own physician

Form sent for review to *(check one)* ☐ Infection Control ☐ Occupational Health ☐ Employee Health

☐ Other *(specify)* _____

Name of hospital employee receiving form _____ **Date** _____

PART C

FOR HOSPITAL USE ONLY (To be completed by appropriate department)

Source Patient's Name _____ **Source Patient's Hospital Medical Record #** _____

Exposed Worker's Designated Officer *(or name of person contacted)* _____

Date Contacted _____

Exposed worker follow-up indicated? ☐ yes ☐ no **Source patient follow-up indicated?** ☐ yes ☐ no

Signature _____ **Date** _____